## MEDIATION RELEASE

NOTE: Patient should make additional copies of this release before returning to the ODA if planning to request medical records from other physicians.

<b>ODA</b>	Case	#		

## PATIENT REQUEST FOR MEDIATION

Upon receipt of this completed form, a mediator will be assigned and will contact you within two weeks to discuss your request and help resolve the issue. Please complete the form and briefly describe the problem(s) specific to the dental treatment received. The mediator will be in touch with you shortly.

Date: Who	referred you to mediation?		
Patient Name:			
Address:			
	State:		
Phone (Daytime):	(E	vening):	
Please indicate the best time of	f day when the mediator can cor	atact you:	
Dentist Name:			
Address:			
City:	State:	Zip:	
Phone:			
Date dental treatment in quo	estion was done:		
Please briefly describe the p	roblem(s) specific to the dental	treatment received:	
What do you feel is a fair sol	ution to this problem?		

Please complete and sign both forms and return to:

Oklahoma Dental Association Mediation Review 317 NE 13<sup>th</sup> St. Oklahoma City, OK 73104

(Attach additional pages as needed)